DOCUMENT RESUME

ED 427 456 EC 307 025

TITLE	Children and Youth at Risk of Emotional Disturbance: Risk Factors and Symptoms.
INSTITUTION	Minnesota State Dept. of Human Services, St. Paul.
PUB DATE	1997-00-00
NOTE	23p.
AVAILABLE FROM	Minnesota Department of Human Services, Mental Health Division, 444 Lafayette Road, St. Paul, MN 55155; Tel: 612-296-4497.
PUB TYPE	Information Analyses (070)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Adolescents; Biological Influences; Elementary Secondary Education; *Emotional Disturbances; *Environmental Influences; Family Influence; Health Services; *High Risk Students; Infants; Mental Health Programs; Preschool Children; Preschool Education; *Prevention; *Student Characteristics; *Symptoms (Individual Disorders); Toddlers
IDENTIFIERS	Minnesota

ABSTRACT

Designed to assist Minnesota educators and mental health professionals in developing comprehensive mental health services for children, this report summarizes research findings and issues in the area of primary and secondary prevention of emotional disturbances in children. It begins by reviewing factors found to contribute to emotional disturbances, including organic factors, stress, and exploitation, and factors found to promote mental health, such as coping skills, self-esteem, and social support. The number of children in Minnesota with an emotional disturbance is discussed, and the following risk factors for emotional disturbance are listed: (1) major physical illness; (2) premature birth; (3) low birth weight; (4) difficult temperament; (5) children who have experienced physical or sexual abuse or neglect; (6) parental illnesses such as schizophrenia, chemical dependence, or mood disorders; (7) insecure attachment to the family; (8) teenage parenthood; (9) homelessness; (10) lack of social support; (11) poverty; and (12) foster care placement. Symptoms of emotional disturbances that indicate the need for some professional evaluation are provided for infants, toddlers, preschoolers and kindergartners, elementary and middle school children, and junior high and high school age adolescents. (Contains 28 references.) (CR)

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Children and Youth

at Risk of Emotional Disturbance:

Risk Factors and Symptoms

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BACKGROUND:

During the development of the Comprehensive Children's Mental Health Act, many parents reported that their child had shown signs of emotional disturbance long before the child was identified as needing mental health services. Yet, many parents were not aware that their child's behaviors were unusual or atypical. In many cases, parents did not seek professional help until their child's problems had escalated. These parents stated that they would have been able to meet their child's needs more effectively if they had had access to services earlier in the course of their child's illness. One parent describes her family's experiences trying to get help for their child:

> Our experience (and I understand this is common, if not universal) has been that many professionals do not take a whole lot of time to figure out what is going on. I can't tell you how many times I have been told, usually by school personnel who have talked to me for a total of three minutes, that my son wouldn't act the way he does if I were a better mother. It would seem to me that a real red flag for parents would be their conviction that something is wrong or different (in some way that seems significant) about their child, especially if other people seem critical of the child or the parenting. (Carol Raabe)

Most emotional disturbances are not preventable. However, interventions early in the course of an emotional disability can reduce the severity of the problem and the resulting loss of functioning in the child, while alleviating the personal distress within the family. Some long-term psychological problems such as character disorders often begin early in a child's life. In some cases, it is possible to identify the kinds of behaviors and symptoms associated with such problems as early as the preschool years and to provide appropriate treatment. In addition, providing mental health treatment to children with mental health problems can be effective in preventing the development of more serious emotional disturbances.

Without intervention, emotional disabilities contribute to an increased risk of accidents, self-injury and death. Clearly, an early response to children with emotional problems can prevent many of these poor outcomes.

With the passage of the Children's Comprehensive Mental Health Act, counties will be expected to develop and coordinate a system of locally available and affordable children's mental health services. Counties are responsible to provide information about "predictors, symptoms, and risk factors" of emotional disturbance in children to various community groups (in conjunction with their local mental health advisory groups). In addition, counties are expected to provide

the community with information on how to access mental health services. (Space has been provided at the back of this report for counties to indicate the manner in which they plan to handle information and referral).

The material summarized in this report will be useful in accomplishing this task. This material has direct implications for the planning and service delivery of "Education and Prevention Services" and "Early Identification and Intervention Services" as well as the actual service delivery and design of other mental health services. A page has been provided at the end of the report which lists the county's mental health number for information and referral services.

Utilizing information on risk factors and protective factors, counties and advisory councils can plan education and prevention services for groups at increased risk of developing emotional problems. In addition, information regarding those groups more likely to develop emotional disturbances can also be used by communities to more effectively target early identification and intervention strategies. It is important to note that some children who have none of the identified risk factors can and will develop emotional disturbances, despite the fact that their family and community have provided extensive social supports.

This report summarizes research findings and issues in the area of primary and secondary prevention of emotional disturbances in children. Readers are encouraged to seek out other resources and information about topics in this area. A list of the primary references and resources used for this report is provided at the end of the paper.

THE NUMBERS:

National studies and commissions over the last twenty years have established a significant number of children with emotional disturbance do not receive needed mental health services. Children, as a group, are an underserved population.

Any child may be at risk of developing mental health problems. (See Risk Factors) Children exposed to multiple stresses in the absence of support will be more likely to develop emotional or mental health problems. However, children with optimum support and low levels of stress can also develop an emotional disturbance.

Many factors interact in determining how many children will develop problems. George Albee, a well known researcher in the area of primary prevention of mental illness, developed a model which links the factors contributing to mental/emotional disturbance with those promoting mental health:

Factors found to contribute to emotional disturbance:

* Organic factors
* Stress
* Exploitation

Factors found to promote mental health:

* Coping skills
* Self-esteem
* Social support

Emotional problems often involve a combination of biological, genetic and developmental factors as well as stress factors. The number of children who develop emotional problems reflects the interactions between the factors listed above. The number of children receiving mental health services in a community is more likely to represent the capacity of the system to provide services, the accessibility of these services, the desire of the families to use those services, and the tolerance of the community for unusual behavior than the need for services.

The exact number of children in Minnesota with an emotional disability is not known. A conservative estimate of the numbers of children with emotional disturbance appears below. These figures were developed in 1981 by Gould et.al. based on their reviews of many studies, and have been supported by the National Institute of Mental Health's Child and Adolescent Service System Program:

* 1 child in 8 (11.8%) has an emotional problem that limits his/her capacity to function.

* 1 child in 20 (5%) has a "severe emotional disturbance".

* An additional 15-20% of all children are from groups which are at higher risk of developing a mental health problem.

Since 1981, there have been several other studies of the prevalence of emotional problems of children in the United States. A recent study by Brandenberg, Friedman and Silver (in press) suggests that the number of children with an emotional disability is likely to be higher than the figures cited above. Their review of recent community studies concludes that it is more likely that 14%-20% of all children have an emotional disturbance. In addition, The National Institute of Medicine (1989) recently reported that 20% of children from low income, inner-city areas may be experiencing an emotional disturbance.

Local studies on various groups of children and youth in Minnesota provide an idea of how many children and their parents have had/would like professional intervention. In Ramsey County, the Wilder

Foundation conducted a needs assessment of county residents in 1987. The portion of the study relating to children's mental health is summarized below:

> Preschool children have mental health problems. In Ramsey County, 9% of middle/high income 4-5 year old and 14% of low income 4-5 year old received professional help with an emotional, behavioral or mental problem sometime during their lives.
>
> In the school age group, 32% of low income parents and 19% of the middle/high income parents felt their children needed help with mental health problems during the previous year. Eighteen per cent of low income parents and 10% of middle/high income parents sought professional help for their children. The Wilder study also established a relationship between levels of family stressors and mental health needs.
>
> In addition, the Ramsey County study found relatively low rates of help-seeking behavior among racial/ethnic minorities. Only 2 percent of low income, racial/ethnic minority children had received professional help during the prior year.

The Minnesota Department of Education's survey of 90,000 children in grades 6, 9, and 12 (from 390 of Minnesota's 433 public school districts during the 1988-89 school year) found that one student of nine surveyed reported a suicide attempt. Students were also asked whether they had ever had any professional treatment for personal, emotional or behavioral problems; 14% said they had. Young people who acknowledged a suicide attempt were more likely to have received professional treatment than others (43% versus 11%.) However, a majority who had attempted suicide had not received any professional treatment.

High levels of stress can be a risk factor for the development of mental health problems; a child's ability to handle such problems will vary depending on the amount of available support and the resilience of a particular child. The Minnesota Student Survey found that large numbers of students felt that they were exposed to high levels of stress in the month prior to taking the test.

Table 1. Minnesota Youth's Perceptions of Stress Levels, Grades, 6, 9, and 12

	Females			Males		
	6th Grade %	9th Grade %	12th Grade %	6th Grade %	9th Grade %	12th Grade %
Stress or pressure (quite a bit or almost more than I could take)	16	33	48	18	24	35

(Source: Minnesota Department of Education, "Minnesota Student Survey Report, 1989)

PROTECTIVE FACTORS:

While it is possible for children to develop mental/emotional disturbances at any point in time, much of the research into competence supports the fact that children who have successfully mastered the stresses of the preschool years and have experienced some success and competence in the early school years are in a better position to master the stresses of the junior high and high school years.

Researchers have begun to identify the many individual and environmental characteristics associated with better outcomes for individuals at risk of emotional disturbance due to vulnerability, exposure to stress, and disadvantage, as well as "protective factors" which promote better outcomes in children under stress. Studies point to the interaction between **community and individual** factors. Factors identified in the research include good problem-solving skills, stress-tolerant dispositions and connections to a supportive, competent adult, such as a parent, grandparent, teacher or child care worker. In addition, community agencies such as schools and day care programs exert a crucial protective role for children, especially with high risk children.

Some protective factors can be preventive, especially in times of stress. Children who lose a parent through death, divorce or separation are at increased risk for mental emotional disabilities, and may need added support at these times.

Schools can help prevent mental or emotional disabilities by developing both academic and social competence in students. Children who develop coping skills such as interpersonal skills, problem solving, empathy, self-awareness and communication skills are generally better able to master many of life's stresses.

In addition, communities can help children suffering from an emotional disturbance to make a faster recovery. For example, children with special needs may need child care services adapted to their individualized needs. Parents and families may need added support services to enable them to meet the strenuous demands of caring for their child.

RISK FACTORS FOR EMOTIONAL DISTURBANCE

Professionals working in health promotion assert that the mental health field has accumulated a sufficient body of knowledge about the kinds of environmental and biological situations which put children **at risk of developing emotional disabilities**, as well as information about the kinds of community and individual factors which improve mental health.

The notion of risk factors comes from the field of epidemiology. **Risk factors** are defined as characteristics of a group of persons associated with greater probability of a disorder, problems or poor adaptation. Some individuals in the group are assumed to be vulnerable; others may not be. The risk is greater for the groups as a whole who share this feature (Masten, 1989).

It is not possible to have a child who is generically "at risk," because risk factors are specific to particular outcomes. This report presents a list of risk factors which increase the likelihood that a child or youth will develop a serious emotional disturbance. Other groups and organizations have collected information on risk factors related to a particular outcome about which they are concerned.

The risk factors and materials presented in this report include those organic and environmental factors which **research** suggests have a strong relationship to the development of serious emotional/behavioral disturbance in children and youth. They are not **causal** factors.

Risk factors associated with the child:

*Major physical illness
*Premature birth
*Low birth weight
*Difficult temperament
*Children who have experienced physical or sexual abuse or neglect

Risk factors related to the family:

*Parental illnesses such as schizophrenia, chemical dependency, or mood disorders
*Insecure attachment to the family
*Teenage parenthood

Risk factors related to the environment:

*Homelessness
*Lack of social support, isolation
*Poverty
*Foster care placement

Many of the factors mentioned above are interrelated; for example, teenage parents are less likely to finish school and have job skills and as result are more likely to be poor, etc. It would be **statistically** accurate to say that groups of children with multiple risk factors are more likely to develop mental health problems. However, it is not possible to predict accurately that a particular child within a group will develop an emotional disturbance.

Because many children at high risk for mental/emotional disturbance will not develop problems, it is important that education and prevention services within a county not create the added stress of assigning high-risk labels to children which results in disruptive or unnecessary interventions; nor should children be shielded from demands and situations which they can master constructively. Persons who work with children must not create a self-fulfilling prophecy by failing to make clear their positive expectations for children or failing to support their development in age-appropriate ways.

SYMPTOMS OF EMOTIONAL DISTURBANCE:

Children with emotional disturbance often do not get mental health services because parents and professionals are unaware of the behavioral symptoms which suggest the need for professional help.

In order to overcome this particular obstacle to service access for children, this report provides material about behavioral symptoms of mental distress shown by children and youth which suggest the need for professional help. This material is organized by age groups so that counties/advisory groups can provide information to community groups based on the ages of children served.

Parents, teachers, and child care providers ought to be key informants for early identification and intervention services. Most community workers such as physicians, nurses, and social workers do not see children on a regular basis. As a result, they are less likely to identify children's mental health problems. Parents and teachers are in the best position to know when a child's development is of concern, although they often do not know what to do with that information. Parents know how their children have responded over time in a variety of settings. As a result, parents' questions and concerns about their

child's development merit a serious response and follow-up. Teachers and child care providers have the most comparative information about normal development and how other children of the same age and cultural backgrounds have responded in school or child care.

As children grow older, they themselves can begin to ask for additional support and help when confronted with serious problems. Some schools have developed innovative health clinics and peer counseling programs which have the potential to provide additional support and access to mental health services as needed.

The course of growth and development in children seldom runs smoothly over time. Concerns which call for attention and wise handling are bound to crop up from time to time. Most children are resilient and manage to cope with problems with some help and emotional support from the adults in their lives, thus preventing minor concerns from developing into larger, persistent problems. Behavior and adjustment problems of children are not always a sign of serious mental health problems.

Learning to interpret children's behavior is complicated by two factors:

* Normal rapid changes in children's behavior due to growth and development make it difficult to decide whether a child is "going through a stage" or having problems that will last.

* Children may develop emotional/behavioral disturbances at any point in time, and the form of expression may be different at different ages. Young children often ask for help with their problems in non-verbal ways. Their behavior may be the only indication that they have too much to handle.

STAGE, PROBLEM, OR EMERGENCY?

Early Identification and Intervention cannot happen unless parents and other community workers can determine how to distinguish between **stages, problems,** and **emergencies** in children.

Emergencies:

Certain symptoms are emergencies and require an immediate response. Such situations include:

* threats, attempts, or persistent thoughts about self-injury or suicide.

* dangerous, intense, destructive, or violent behaviors, including fire-setting or assault.

* severe withdrawal, isolation and inability to carry on daily routines, including eating, sleeping and playing.

If a child shows these signs, parents, teachers, and/or community workers should immediately seek emergency services through a mental health clinic, family health care provider, county mental health hotline, or local crisis or emergency care center.

Suicide attempts have become more common among Minnesota children. When Minnesota's youth suicide rates began an upward trend, the Department of Education encouraged Minnesota's individual school districts to develop policies to address the problem of youth who are at risk of suicide. Risk factors and symptoms identified through this initiative are provided below, and are arranged in order of degree of risk, from situations of less acute risk to those of most acute risk.

* Depression
* Loneliness, poor self-esteem, isolation
* Family stress
* Fear of punishment
* Violent behavior and/or character disorders
* Running away
* Alcohol and/or drug abuse
* Learning disabilities
* Concerns about sexual identity
* Loss of a loved one
* Teenage pregnancy
* Change in school performance and/or relationships with friends
* Other teenage suicides
* A family history of suicide
* Suddenly putting affairs in order/talking about committing suicide
* Immediate access to the means to kill himself/herself

DEVELOPMENTAL STAGE OR PROBLEM?

Responses to some questions provide guidance about when a normal developmental "stage" has become a "problem." If a child has one or more symptoms and the parent or teacher can answer "yes" to at least one of the following questions, it is likely that the child should be referred for a mental health assessment.

* Does this problem keep the child from doing things that other children the same age are doing, such as being part of a sports team, having friends, eating, sleeping, and/or succeeding in school?

* Does this child have more problems than other children of the same age or have a continual series of changing problems?

* Has the child had this same problem for a long time? (Some problems may need immediate attention; others can be followed closely for a period of time.)

* Does this child's problem appear more serious than those of other children of a similar age?

* Does this problem occur in several settings (in the classroom, at home, on the playground, or in the community)?

* Has a parent or teacher attempted to improve the situation for the child, and if so, have these efforts failed to improve the situation ?

* Does this problem appear to cause a high degree of personal suffering for the child or family ?

It is important to determine how children's behavior affects their daily lives by answering the questions above. In addition, parents and community workers are encouraged to seek professional help for symptoms and behaviors which make the parent or teacher uneasy or suspect that a child is experiencing an emotional disturbance, even if such behavior symptoms are not part of this list. Since children are unique, they will have unique ways of showing distress. Some of those symptoms will be different from the ones mentioned here.

The following lists of symptoms provide descriptions of behavior often shown by children (or noticed by adults) that indicate the need for some professional evaluation. The lists are arranged by age level in order to allow more age-specific information to be distributed to community groups. Readers should remember that some of the behaviors described are not problematic in and of themselves, since it is normal for children to experience anger, fear, sadness, and opposition to authority in the course of growing up.

INFANTS:

Symptoms of mental/emotional problems in infants appear most often as delays in development. The following collections of symptoms are a sign that professional help should be sought. Evaluations of infants should include primary health providers in order to rule out physical bases for problems.

* The infant who does not turn to sound, does not look at bright or moving objects, does not track visual stimuli, or reach for an object near his grasp.

* The infant who over-responds to any external stimulus (i.e., noise, touch, or light) startles easily, cries, and covers her ears or eyes.

* The infant who, by about 16 weeks, does not smile, gurgle, or otherwise show pleasure when approached or cuddled.

* The infant who sleeps little and cries for long periods of time and is not able to be comforted, when this does not appear to be related to gastrointestinal distress or colic.

* The infant of 40 weeks to 1 year who typically does not cry when mother leaves or has been out of the waking infants's sight for a period of time.

* The infant who, at around one year of age, does not yet seem to differentiate between strange and familiar persons, e.g., shows no fear of strangers such as doctors and nurses or no particular recognition of his mother. In effect, the infant does not seem to notice who is caring for him.

* The infant around one year of age who does not begin using simple sounds and/or words which have meaning to the child and family to obtain food or toys or to get other needs met.

* Failure to thrive shown in an infant by weight loss or inadequate weight gain for age, not explainable by any physical disorder.

* Failure to acquire other normal developmental milestones usually expected in infancy.

TODDLERS:

The toddler stage of development is a particularly challenging one for adults. Much of the normal, expected behavior of a toddler flies in the face of the needs of parents and/or child care providers' expectations of how children ought to act. Toddlers' limited language, strong urge to explore, and desire to establish a sense of self often pit them against the wishes of adults. Sorting problems from developmental stages at this age can be difficult. Symptoms of "problems" in a toddler are:

The Toddler

* The toddler who shows developmental delays of six months or more in language, motor, or cognitive areas.

* Toddlers who are totally engrossed in themselves, engaging in self-stimulating behaviors such as hand-waving, clapping, etc. as a major activity.

* Toddlers who repeatedly harm themselves physically, biting or pinching themselves or banging their heads, etc.

* Toddlers who generally appear sad, cry, or show no appropriate signs of pleasure, sadness, fear or anger.

Relationships

* Toddlers who appear indifferent to adults who care for them, and do not form a relationship with day care providers.

* Toddlers who frequently hit, kick, bite, or fight with other children or adults with an intention to do harm.

The Environment

* The overly active toddler who is constantly and inappropriately engaged in physical activity, who is into everything, breaking everything or showing no restraint. This child has difficulty sitting to listen to even short stories and is constantly on the move.

PRESCHOOLERS AND KINDERGARDNERS

The Child

* The child who cannot attend to a stimulus or an activity for an age-appropriate period of time, but who constantly "spins" about from one thing to the next without getting involved in anything.

* The child who is totally engrossed in himself, engaging in self-stimulating behaviors such as hand-waving, clapping, etc. as a major activity.

* The child who shows a depressed mood, indicated by continual sadness, boredom or lack of interest. The child may show a loss of energy or enthusiasm or a preoccupation with morbid ideas.

* The child who lacks confidence in herself, frequently saying I "can't" or who otherwise criticizes herself.

* An unusually anxious or fearful child whose fears interfere with normal activity. Examples are excessive fear of strangers, new situations, water, physical activity, etc.

* The child who frequently plays out negative experiences such as abuse, natural disaster, accident, witnessing a murder, or war. These children may have additional physical symptoms such as headaches or stomach aches. They may lose recently acquired developmental skills such as toilet training or language skills.

* The child who is not daytime toilet trained within the range of other children the same age.

* The child whose development appears to be six months behind others of a similar age; and activities to improve this slow development have not helped.

Relationships

* Children of 4 or older who cannot involve themselves in group activities or interactive games with other children. They may be oblivious to activities or stand on the sidelines, resisting attempts to get them involved.

* Children who do not begin to make a transition from physical to verbal relationships with others by age 4, who relate by hitting, kicking, pulling, or biting.

* Children who are excessively dependent upon parents or who can spend no time alone, whine, cling, cry excessively upon separation. For example, these children cling to their parents rather than exploring toys or materials or interacting with other children.

* Children who show no interest in parents or other children, occupying themselves primarily in solitary pursuits.

Home or School

* Children who at age 3 1/2 or 4, cannot share or wait their turn.

* Children who destroy their environments or aggressively act upon things, breaking toys, throwing things, tearing, cutting, burning, or otherwise inappropriately defacing property. (This type of destructiveness needs to be distinguished from the normal amount of breaking which may happen in the course of exploratory play.)

* Children who have been removed from a child care setting one or more times because of their behavior, or whose teachers frequently report problems at school which require restricting the children's privileges due to their behavior.

PRIMARY AND MIDDLE SCHOOL CHILDREN:

The most common form that mental health problems take in the school-age child are problems with school work and/or the ability to establish friendships with other children.

The Child

* Children who appear disinterested in activities, spend more time on their own, and do not respond to friends, or get involved in extra-curricular activities.

* Children who behave in a bizarre manner. They may hear voices and/or have odd delusions that they are controlled by another person, or that someone is sending them messages.

* Children who are often sick with headaches, stomachaches, nausea or vomiting. These children may refuse to come to school.

* Children who have experienced abuse, natural disasters, accidents, witnessed homicides, or war and may repeat the event in play. Other symptoms include avoiding thoughts or feelings about the event and avoiding activities or situations that remind them of the traumatic event. They may feel detached from people, take less pleasure in previously enjoyed activities, have trouble sleeping, have nightmares or have difficulty concentrating. They may have various physical symptoms such as headaches and stomachaches.

School

* Children who show delays in development in reading or arithmetic. These delays in school years are usually picked up by school personnel. Teachers, parents, and adults should be concerned when a child's development seems to lag behind other children, and no plans have been made to remediate them; or when the child is not able to make any progress on developmental goals.

* Children whose school performance shows marked changes based on prior achievement levels. These children seem unable to meet the expectations of teachers for homework or in-class assignments.

* Children who have difficulty finishing activities because they don't appear to listen to the teacher's directions or parental requests. They can become dependent on parents to help them with school work because of this problem.

* Children who are frequently "on the go." While in their seats in the classroom, they are constantly moving, or playing with materials. These children may talk excessively.

Relationships

* Children who have friends, but tend to be callous or manipulative toward other children or adults to whom they are not emotionally attached. They appear to deliberately seek out much younger children to dominate, manipulate, and control.

* Children who are fearful of new persons and situations to such a degree that it impacts their friendships and general social functioning.

* Children who have difficulty forming relationships with peers, and appear to have immature social behaviors, such as baby talk or "little kid" voices. They may tend to play with younger children on a regular basis.

* Children who display their aggressiveness by patterns of obstinate, but generally passive, behavior. They appear to be conforming, but continually provoke parents, teachers or other children by their use of negativism, stubbornness, dawdling, procrastination, and other measures.

* Children who easily and unpredictably lose their temper or argue with parents, frequently blaming others for their problems.

* Children who have poor relationships with peers. They may be egocentric and manipulative, lack concern for the welfare of others and be without guilt or remorse. Typically, these children have a reputation as a "loner."

* Children who seem unaware of the consequences of their actions. They have difficulty waiting their turn during class activities or when playing games with other children.

* Children who are easily distracted from their class work and activities by noise or by the presence of other children.

JUNIOR HIGH AND HIGH SCHOOL AGE ADOLESCENTS

Most of the symptoms and problem behaviors of the early school years also indicate problems in the later school years. However, some additional mental health problems first appear in adolescence.

Adolescents' increasing competence can make it more likely that they will act in a way that is self-destructive and/or self-injurious.

Adolescents

* Youth who appear to have lost interest in previous activities and persons for a period of at least two weeks. The youth can be very restless or slowed down. They may need more and more sleep, or have insomnia. They may lose and/or gain weight.

* Youth who behave in bizarre ways. They may hear voices and/or have odd delusions that they are controlled by another person, or that someone is sending them messages.

* Youth who have difficulty concentrating, as demonstrated by declining school performance. These youth may refuse to talk to parents or adults. They express feelings of worthlessness or guilt.

* Youth who talk about suicide or make plans to give away possessions, etc. (See prior list of risk factors and symptoms).

* Youth who fear a specific object, activity or situation. For example, they may fear heights, airplanes or crowds.

* Youth who are obsessed or concerned with body shape and weight, whether they are unusually thin or of normal weight. They may have distorted perception of their weight and think certain body parts are "fat" when they are actually thin.

* Youth who appear extremely elated or "hyped up." They may act all-powerful. They may talk excessively and laugh continually. They may go on shopping sprees, spending more money than they have. This behavior could last from a few days to months.

* Youth who have experienced abuse, natural disasters, war, or witnessed homicides, may avoid thoughts or feelings about the event and may avoid activities or situations that remind them of the event. They may appear detached from people, take less pleasure in previously enjoyed activities, have trouble sleeping, have nightmares or have difficulty concentrating. They may have various physical symptoms such as headaches and stomachaches.

Relationships

* Youth who are often aggressive toward others, including sexual and physical aggression.

* Youth who break rules at home or at school, and may be truant from school, abuse chemicals, or run away.

Environment

* Youth who destruct other's property or possessions, including vandalism and burglary.

* Youth who are engaged in burning property.

CONCLUSION

Children are our future. When we respond to their mental health needs and the needs of their families, we invest in our own future. It is not enough to work with children who already have serious emotional problems. Communities need to obtain the resources necessary for the promotion of mental health such as physical well being, self-esteem, and social support. Communities need to adopt societal policies and attitudes which support all individuals in a just and equitable manner.

This report summarized much of the information on symptoms and predictors of emotional disturbance in children as identified by researchers and national study groups. While this information may be repetitive for some, it is hoped that the report will be used as a starting point for children's mental health planning and program development.

Working to improve the lives of children demands that we work together with other community groups and organizations. Given the interaction of the factors necessary for sound mental health, strengthening resources in one area can help counteract risk factors in other areas. This approach requires systems which coordinate a variety of disciplines and agencies which are outside the scope of the mental health system. **Prevention is a concern for all societal institutions that provide human services. It is the responsibility of mental health leaders to provide leadership, guidance and advocacy.(National Mental Health Association, 1986).**

In summary, it is up to each of us to demonstrate the commitment and support for activities which promote the emotional, well-being of our communities' children.

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ACKNOWLEDGMENTS

Special appreciation is extended to the following individuals for sharing their time, knowledge, and resources, as well as reviewing drafts of this information:

Louise Brown, Jim Collier, William Dikel, Susan Erbaugh, Sandy Ferrell, Erna Fishhaut, Carol Kaste, Roger Israel, Dixie Jordan, Ann Masten, Ron Pitzer, Harriet Pratt, Carol Raabe, George Realmuto, Dave Sanders, Sue Serbus

The following persons in the Departments of Health, Education, Human Services and State Planning were very helpful in sharing resources and responding to requests for information as well as commenting on earlier drafts of this report:

Jean Cronje, Tom Grey, Mary Kay Haas, Ann Jaede, Barbara Kaufman, John Langworthy, Diane Miller, Jerri Sudderth, Joan Sykora, and Jan Gibson Talbot.

Finally, the Mental Health Division wishes to express its appreciation to Diane Bick for her research in assembling this material.

Local Information

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